Trading futures: Sadaqah, social enterprise, and the polytemporalities of development gifts

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Trading Futures
Sadaqah, social enterprise, and the polytemporalities of development gifts

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Abstract: In this article, we explore what happens when idea(l)s of Islamic charity (*sadaqah*) and social enterprise converge within a low-cost public health clinic in Colombo, Sri Lanka. For both the clinic's wealthy sponsors and the urban poor who use it, interpreting the intervention as a pious expression of care toward the poor or as a for-profit humanitarian venture meant extending different futures to the poor. The ambiguous temporalities of gifts and commodities anticipated by benefactors and beneficiaries involved in this challenges anthropological assumptions concerning the marketizing effects of neoliberal development interventions. Our ethnography revealed a hesitancy among the clinic's sponsors, managers, and users to endow the intervention with a final interpretation, undermining its stated goal of promoting health care privatization and "responsibilization" of the poor.

Keywords: Charity, gift, Islam, social enterprise, Sri Lanka, temporality

Tucked away in the backstreets of Slave Island, a bustling but low-income Malay quarter in the Sri Lankan capital of Colombo, an unassuming medical center provides free health checks and cut-price prescriptions for local residents.[1] CommClinic, a non-profit initiative of a wealthy Muslim family originating in a gift of *sadaqah* (voluntary charity) delivered via the corporate social responsibility (CSR) team of the company they own, was one of three options for medical treatment available in the area. The other two, a tax-funded municipal health center and a doctor's private surgery, had reportedly struggled to attract users since the appearance of CommClinic some three years earlier. Insofar as CommClinic was able to successfully attract both low- and middle-income patients and change health seeking choices in Slave Island, it had succeeded in its stated mission of "bridging the gap" between public and private health sectors in Sri Lanka. CommClinic proved attractive to patients, ostensibly at least, because it combined the presumed benefits of public and private health provision (affordability and customer focus, respectively) while solving some of their problems (specifically, waiting times and a lack of trust) (see Russell 2005; Russell and Gilson 2006).

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Our opening portrait of health market "diversification" in Colombo that CommClinic represented obscured a complicated set of moves through which actors launched, delivered, and used the service. We referred to multiple kinds of economic, social, and political language and practice that imbued the service—from Islamic charity[2] through CSR to the needs and aspirations that directed patient choices between private and public services. Underpinning those models and modalities of health care was a shifting commitment on the part of the program's benefactors to replacing beneficiaries' exposure to financial indebtedness caused by high private health care costs, with a moral obligation to taking on responsibility for their own economic well-being. As CommClinic unfolded, this ambition proved more complicated than it originally appeared to be, in terms of how benefactors, managers, and users actually made sense of the program's stated charitable origins, compared with what it became at point of delivery—a fee-based service. The contestations that arose around aspirations for converting financial debts into moral obligations via religious gifts and commercial relationships reveals some of the practical and conceptual conflicts that arise when the different temporalities that adhere to gifts and commodities collide within a single organizational setting.

We approach these issues by asking what CommClinic meant for the different actors involved in its design, delivery, and use. Social enterprises can include charities running money-making ventures providing an income stream, to regular businesses that direct profits to humanitarian and development activities. The concept of social enterprise is ambiguous, with legal, financial, and organizational form varying between historical and social contexts and regulatory regimes (Kerlin 2009). They resemble what Marianne de Laet and Annemarie Mol (2000: 225) have called "fluid objects"—unbounded organizational forms that are "adaptable, flexible and responsive." Within the context of global health and development where intervention models routinely "travel" (Petryna 2009), fluidity has helped to make social enterprise compatible with otherwise incompatible models of health care delivery—for example, by simultaneously embodying charitable and market models.

Alongside other "bottom of the pyramid" (Prahalad 2005) interventions, social enterprises like CommClinic are rooted in a belief that only once the poor take responsibility for their own lives and are provided mechanisms for doing so can they escape the causes of poverty. A growing critical literature has shown how such approaches can also drive cuts to public services and engender new forms of economic, social, and health marginalization. Taking the shape of what Julia Elyachar calls "empowerment debt" (2005) and Ananya Roy defines as "poverty capital" (2010), the poor are encouraged to develop an ethic of self-care attuned to neoliberal logic (Cross and Street 2009; Dolan and Johnstone-Louis 2011; Dolan et al. 2012; Elyachar 2012; Lazzarato 2012; Rajak 2010; Watanabe 2015). By "helping the poor to help themselves" via the transfer of an entrepreneurial spirit via which the poor can adopt an attitude of personal responsibility for their future well-being, something of the benefactor travels to beneficiaries (Allahyari 2000; Atia 2013; Muehlebach 2007; Osella 2017; Tittensor 2014; Trundle 2014).

While anthropologists have revealed how such motivations transform ostensibly altruistic or pious intentions into a more complicated and interested act, they have rarely discussed the organizational mechanisms of subjectivation itself. Anthropologists have also only sparingly attended to recipients' own experiences of such processes (Copeman 2011; Gregory 1992; Osella and Widger 2018). The metaphors that anthropologists have used to describe the "social life" (Appadurai 1986; Stirrat and Henkel 1997) of gifts that "travel" (Ong and Collier 2005; Petryna 2009) from givers to receivers thus reveals an assumption that programs like CommClinic operate in broadly linear terms—with largely unambiguous foundational values transferring more or less unfettered to passive consumers. There has been surprisingly little attention paid to the question of whether benefactors hold true

to their own ethical vision, or whether beneficiaries respond positively toward, let alone care for, the subjective transformations of "responsibilization" that such interventions apparently seek to engender (Trnka and Trundle 2014). In what follows, we point to the struggles that benefactors experience in actually delivering what they set out to achieve in terms of the ethical transformation of the poor "other," and the circulation or counterflow of meaning that emerges from beneficiaries' acceptance, translation, redeployment, or refusal of those benefactors' aspirations.

The article draws from ethnographic research conducted over a period of 18 months, from February 2012 to July 2013. First, we interviewed two of CommClinic's original benefactors, LankaComm's current and past CEOs, Bilal and Esmail, at company headquarters. Second, we held four separate meetings with LankaComm's two-person CSR team, Samuel and Nimis, over a period of several months as we conducted longer-term fieldwork in CommClinic settings in Slave Island and Grandpass. Third, we conducted a household survey and collected case study examples of CommClinic use among a sample of 66 local residents in both communities. The article begins with a brief introduction to the Sri Lankan health care market and the significance of CommClinic within processes of service provider diversification and privatization that have been taking place over the past few decades. The next three sections follow the design, delivery, and use of CommClinic from the perspectives of LankaComm's CEO and CSR team, and local people in Slave Island and Grandpass. By way of conclusion, we reflect on how the fluid meanings of CommClinic and paying closer attention to beneficiaries' responses challenges anthropological assumptions concerning the subjective transformations instigated by philanthropic interventions.

The Sri Lankan health care "market"

The origins of the Sri Lankan health care system lie in philanthropic investment in hospitals and other infrastructure during the nineteenth century (Hewa 2012; Jones 2009). Following independence from British rule in 1948, the post-colonial government launched a "Free Health" policy in 1951 that saw the nationalization of charitable and private hospitals and the establishment of free-at-point-of-use curative and preventative services funded through general taxation (Alailima 1995; Silva 2009). The outcome of sustained public investment across the second half of the twentieth century has been the development of an extremely high quality health care system, especially in relation to preventative services, and excellent performance on population health indicators (Gupta et al. 2013; Samaratunge and Nyland 2006).

At the ideological level, free public health care remains a central commitment among all the major political parties—even while pressure from international donors including the IMF (International Monetary Fund) led to gradual privatization from the late 1970s (Kumar 2019). Today, public health care comprises just 50 percent of outpatient care, although it still accounts for 90 percent of inpatient care. While private inpatient services remain beyond the reach of all but the wealthy middle and upper classes, outpatient services (clinics and dispensaries) offering routine health tests, consultations, and prescriptions have burgeoned and are, in principle at least, accessible to all but the very poorest. Thus, around half (54 percent) of health spending in Sri Lanka comes from private sources, including 85 percent paid out-of-pocket, 5–8 percent paid via employer benefits, 5 percent paid via health insurance, and just 2–3 percent covered by the non-profit sector (Kumar 2019).

Although Sri Lanka has so far not experienced significant levels of health care "diversification" seen in other countries, the gradual expansion of a health care market has worked to challenge public provision on both practical and ideological grounds. Publically funded curative services have suffered from chronic underinvestment leading to staff and resource shortages, which has, in turn, led to a growing political acceptance and appetite for the

development of a market model incorporating private and public-private providers (Kumar 2019). The majority of medical practitioners employed in the private sector remain public sector employees, and divide their day between both sectors—often working in public settings in the morning and private settings in the evening. A much-repeated complaint among the public in Sri Lanka is that state services suffer due to the time constraints this places on medical staff wishing to "get away" to their (lucrative) private clinics.

The relatively high price of private health care poses a significant risk to the financial security of low-income households. Steven Russell and Lucy Gilson (2006) showed that for those with the lowest incomes in Colombo, the existence of free health care was an important social protection measure as even the smallest health expenditure could tip a household into poverty and debt. A study conducted by the Catholic development NGO Caritas (2012) provided an indication of the levels of debt in Colombo's low-income communities, much of which a preference for or being forced to choose private health care in the absence of public health care had created. The researchers found that for the urban poor, the "escalating costs of living and the fact that their meagre savings could not meet the expenses related to sudden shocks such as illness . . . in the family" was a cause of indebtedness (Caritas 2012: 38). Similarly, The Women's Bank of Sri Lanka[3] has argued that health care costs are a significant cause of household debt.

Given the popularity of free health care in Sri Lanka among the public and its continued importance in poverty reduction and social protection, the growing market for private health care options is perhaps surprising. Russell and Gilson (Russell 2005; Russell and Gilson 2006) have suggested that while public services in Colombo tended to enjoy greater levels of public trust overall (for example, they were seen by respondents to their research as subject to greater levels of accountability and oversight), private services were popular simply because patient waiting times were shorter. According to Russell and Gilson's interlocutors, private services benefited from a narrative of convenience, which when it came to minor health complaints was valued as more important than trust by their research participants. As our own findings discussed below suggest, a confluence of subjective transformations linked with the re-valuation of time and status found in narratives of convenience and waiting helps to explain the growing acceptance in Colombo of the idea that health care can be paid for, as well as being one of the central messages accompanying CommClinic branding.

It has been against this background of market diversification on the one side, and growing risks of health inequality on the other side, that recent philanthropic investments in health have played out. Our research in Colombo revealed very high levels of voluntary investment in health infrastructure, public health drives, community health camps, and patient sponsorship—amounting to what we term a *health philanthroscape* (Osella et al. 2015). Sri Lanka also boasts the highest levels of blood, organ, and whole body donation in the world, with the supply in corneas outstripping local demand to such a degree that the island exports tissues to countries around the world (Simpson 2017). For many Colomboites we spoke to, health represented a productive field for participation as both givers and receivers of gifts and donations, generating material and spiritual merits and blessings for the healthy wealthy and the deserving poor—and for the poor whose gifts of small change and blood and tissue donations too offered pathways to social and spiritual satisfaction.

The future uses of *sadaqah*

It was thus into this health philanthroscape of economic and spiritual economies (Rudnyckyj 2010) that the owners of LankaComm, one of Sri Lanka's biggest conglomerates, decided to enter when they launched CommClinic. Accord-

ing to the company website, CommClinic was "inspired by the idea of providing free medical consultation and subsidized drugs to patients." The aim was to appeal to "patients from lower income segments who are unable to afford the usually high-priced private health care system . . . by giving an affordable solution to the people without compromising on quality and efficiency of health services." In 2013, it was company policy that no prescription should cost more than Rs.200 (ca. £1.00), while the average cost of a private prescription was Rs.800 (ca. £4.00).

We met one of LankaComm's founding members in his office at the company headquarters, a new three-story building off Colombo's central Galle Road. Bilal was a cordial and jovial man, peppering our conversation with jokes about himself and his Memon Muslim community. He was keen to stress that he was a very busy man. He had just returned from a business trip to Dubai, and when we met he was preparing to leave for Singapore and Hong Kong to "inaugurate two new companies of the LankaComm group." "Our chat will be short," Bilal told us, but we could then talk at length with two of his employees who managed LankaComm's CSR (corporate social responsibility) programs.

Bilal together with his four "cousin-brothers" (father's brother's sons) founded LankaComm PLC in the late 1970s with the modest capital of £1,500. After 35 years, LankaComm had developed into one of Sri Lanka's most successful corporations, and although the cousin-brothers floated the company on the Colombo stock exchange in the 1990s, the founding family retained a controlling stake. Bilal was extremely proud of his business achievements, but it was not a rag-to-riches story. The family had its roots in Gujarat where they had run a thriving textile business. On the eve of Partition, escalating attacks on Muslims convinced Bilal's grandfather to send his two sons to Colombo to set up business there, "just in case conditions worsened." The rest of the family stayed put in Gujarat until after Independence, but left for Colombo after anti-Muslim violence that followed Gandhi's assassination in January 1948. The original plan was to move eventually to South Africa, but "business was good in Colombo, so we stayed here," Bilal told us. "We are Muslim Memons," he said with a glistening smile, "business is in our blood!"

A successful entrepreneur, Bilal was as keen to talk to us about his charitable endeavors as he was his family history. He explained how the vast majority of what he gave took the form of *zakat*, the compulsory monetary alms that all Muslims of a certain financial worth must give, and *sadaqah*, a term that translates as "charity" and encompasses any form of spontaneous or planned assistance to others—be it in the form of cash, kind, or time. Bilal was keen to stress that the Islamic laws governing the value and destination of *zakat* and *sadaqah* aside, he gave both with equal commitment to ensure he supported only worthy causes for achieving maximum return. Bilal declined to tell us how much *zakat* he gave every year, because "it is a personal matter between God Almighty and me." "Also," he grinned, "if I tell you the amount, you will be able to work out my assets, and this is private too!"

However, Bilal did talk freely about the *sadaqah* (voluntary charity) he gave, much of which he still channeled collectively with his brothers via the company's CSR team. Bilal explained they ran a number of different schemes to help "the poor, mainly Muslims," including help to start a small business, pay for marriage expenses and medical emergencies, and provide interest free loans. They also gave money to the local Memon Association and two well-known Muslim charities, the Ceylon Baitulmal Fund (established in 1957 by a prominent Colombo Muslim politician; see Osella 2017) and Mercy Lanka (a social service organization funded by Al-Rahma International of Kuwait). Among those interventions was CommClinic, LankaComm's jewel in the crown—the most ambitious and most expensive program the brothers had supported.

For Esmail, LankaComm's former CEO, CommClinic's ethos was grounded in the Islamic commitment to assisting the poor and

needy living in close proximity oneself. During an interview, he told us, "[Islam teaches] that if someone in your neighborhood is starving it's a sin for you to have proper meals or fill yourself up." It was for this reason that LankaComm opened the first CommClinic in Slave Island, a short walk from LankaComm's headquarters off Galle Road. Esmail also stressed their involvement in the program adhered to the ethic of disinterested giving associated with *sadaqah*, in that the brothers' involvement in CommClinic had never been highlighted, and neither had LankaComm's backing of CommClinic featured as part of its branding. Repeating the well-worn phrase "the left hand should not know what the right hand is doing," Esmail insisted that CommClinic be run independently from its benefactors' personal or business interests—that the gifts that launched and sustained CommClinic during the first few years of its life were "pure."

Nevertheless, how LankaComm then delivered the gift to recipients complicated these claims. The focus on health care itself emerged from what Esmail had described as a gap in the market for private services that was oriented to the needs of low-income people:

> There is severe gap between the service providers—the government hospitals and the private hospitals—there's a huge gap. The health sector is costly for private prescriptions. . . . The government service is uncomfortable and not good. . . . And the people who go to the government hospitals just can't afford to pay for the services you get from the private hospitals, so we want to bridge that gap.

For Esmail, the gap that existed between public and private health care was not only one created by the variable standard and cost of service. It was also rooted in the challenge that it presented in terms of cultivating an ethic of appreciation and respect among the poor. Such uplift would emerge from the very fact of paying for a service. As Esmail told us: "People have just become used to getting medicines for free. When they are sick but don't have money they don't get help. It's better if they pay something because then they value what they have and work harder to keep it."

Throughout our fieldwork in Colombo, we regularly encountered the belief that charity recipients failed to appreciate the help they were given unless required to "give something back" (Osella et al. 2015). Middle class interlocutors worried this had the effect of encouraging dependency, despondency, and lack of self-esteem among the poor, and it also signaled their inability to participate in "spiritual economies" (Rudnyckyj 2010) of gifting that provided a key means through which blessings and merits could be accrued (Haniffa 2017; Osella 2017)—a distinctive feature of the Sri Lankan health philanthroscape. For some organizations, including LankaComm, the social enterprise model that combined a fee-based approach with an ethos of "affordability" and "inclusion" (summed up in its motto of "bridging the gap") provided a framework within which those marginalized from economies (spiritual and otherwise) could begin to participate by "think[ing] about debt, investment, and loss in statistical terms" (Appadurai 2013: 4). The solution that LankaComm came to, as Esmail explained it, was deceptively simple: "Two years back our chairman had an idea. The consultation will be free, medicines sold at cost price."

To that end, Bilal and Esmail both revealed aspirations that CommClinic could become a leading example of "pro-poor" private health care in the developing world. In 2014, after just four years of being in business, CommClinic celebrated its one hundred thousandth "customer." Fees levied that same year exceeded operational costs, making the program profitable for the first time. Recognizing a market opportunity when he saw one, Esmail described how LankaComm was now seeking to consolidate its foothold in the health care sector. Their strategy would entail opening not only a dozen or so new CommClinic sites outside Colombo, but also a full inpatient hospital in Colombo. To achieve that goal, Esmail was also wary that they had to move quickly, because the risk of com-

petition was rising: "What we feel is, if we get this concept going, we might find a lot of other people following suit . . . [A] lot of the corporate bodies might want to do this as one of their CSR projects. So we might set the trend." Yet LankaComm's vision to "bridge the gap" between public and private health care also transformed the nature of the relationship implied in the giving and receiving of *sadaqah*—a shift that played on the minds of Bilal and Esmail, who were both keen to stress they received no financial return from their donation. However, by charging a nominal fee, LankaComm had also proven that the CommClinic program could sustain itself without further charitable intervention on the part of the founders. The originating gift of *sadaqah* was thus temporally sealed off from its point of delivery in a fee-based service, retaining its character as a "pure" development gift (Stirrat and Henkel 1997). And it was precisely for this reason that Bilal and Esmail could stress that although a business, CommClinic offered an excellent vehicle for discharging their obligations to God, by "helping the poor to help themselves." It was through the introduction of a fee-paying model of health care that Colombo's urban poor were to be uplifted, simply by becoming more familiar with the concept of "paying their way."

The risks of commodification and the protective force of charity

Operational responsibility for the CommClinic program lay with LankaComm's small CSR team, consisting of a director, deputy director, and a couple of administrative staff. Samuel, the CSR director, was keen to share the contributions of his own vision and efforts in the success of CommClinic. When we met, Samuel had just finished reading a book on social entrepreneurship published by Richard Branson, the founder of the Virgin business empire. Samuel explained that Branson had recently launched a website showcasing innovative social enterprise models, and Samuel was working on submitting CommClinic. The challenge that Samuel faced involved a struggle to reconcile the two sides of CommClinic that Bilal and Esmail had also told us about: on the one hand, the program originated in a gift of *sadaqah*; on the other hand, it had adopted a business model. Perhaps because he was a Christian, or perhaps because the gift did not originate from him, but for Samuel the difficulty lay less in the possible tensions of marrying religious orthopraxy with market rationality, than it did in the different subject positions that CommClinic "users" or "customers" would subsequently occupy in service settings.

The major advantage of a social enterprise model, as Samuel saw it, was the avoidance of what he called the "charity problem." In terms echoing Esmail's, Samuel explained that although "[medicines] are free from the government, the problem is that our people don't respect things if they are given for free, so we charge a small amount." By levying a fee for CommClinic's services, Samuel wanted to foster what he called an ethic of "self-respect" among the poor. However, in this Samuel also recognized a potential risk. By requesting payment, CommClinic also acquired new responsibilities toward its patients, whose status transformed from recipients to customers. With such transformation came new expectations on the part of "customers" for a service akin to that provided in the private sector. Meanwhile, charges of inefficacy or medical negligence could lead to negative media reports or claims for compensation. Ironically, Samuel argued that as a charitable service, CommClinic had the right to refuse treatment to anyone whose ailments exceeded the limited capacity of the clinic. As Samuel explained, "There is a risk of litigation and as a CSR project we want to avoid that. We stay away from serious accidents. We've told the doctors not to admit any patients who are serious but to always send them to hospital. We have to protect our brand." Samuel's solution was to reemphasize LankaComm's charitable underpinnings, which he regarded as providing the best defense against the predicaments of a market relationship implied by social enterprise. In so doing,

CommClinic was able to cherry-pick the least serious medical cases, leaving to public hospitals those deemed too costly and time-consuming, or altogether intractable—a move that transferred risk from CommClinic back into the public sector.

Samuel's approach to risk mitigation also meant resisting a firm categorization of what CommClinic was supposed to be—a charity or a social enterprise. If the future that CommClinic represented was in the business of low-cost private health care, then LankaComm needed to accept the liabilities and risks that came with it. However, if LankaComm wanted to reduce its exposure to risks, then CommClinic was compelled to reoccupy the ground of charity. Just as Bilal and Esmail had left the future of CommClinic open to determination as means of protecting the purity of their original gift of *sadaqah*, Samuel avoided a firm designation for CommClinic as a means of protecting the CommClinic and LankaComm brands from damage.

Choosing futures that fit: On using CommClinic or not

Thus far, we have described the kinds of futures that CommClinic's benefactors and managers imagined they could or should offer the poor, and how such temporal commitments shaped the ways they imagined CommClinic might deliver health care. We now move to consider how those who lived near CommClinic branches in two inner city neighborhoods in Colombo responded to those visions. At Slave Island, the clinic was located opposite a government housing scheme, to the rear of which were illegal "encroachments" that over the decades had developed from slum dwellings into solid, well-maintained homes.[4] At Grandpass, the clinic was located in a maze of multistory encroachments of better quality than those found at Slave Island. A range of public and private health care facilities, within walking distance or a short bus or trishaw ride away, served both communities. At Slave Island, a municipal dispensary, open between normal working hours (8am and 4pm), was located at the end of the road some five hundred yards from CommClinic. Samuel had explained that when CommClinic opened, a nearby private dispensary soon closed because it could not compete with CommClinic's low prices. At Grandpass, however, a private dispensary close to CommClinic remained in business, apparently because many residents had not yet been enticed by CommClinic's offer of cheaper care.

Our research in Slave Island and Grandpass began with a door-to-door survey, which then provided opportunities for longer interviews. Some simple numbers generated by the survey help to establish patterns of outpatient care in both communities. Our results suggested that of the 66 (Slave Island, $n = 35$; Grandpass, $n = 31$) residents we spoke to, 73 percent had used CommClinic service at least once over the previous six months. At Slave Island, 46 percent of respondents said they used the local municipal services when not using CommClinic, compared to just 9 percent who used private services and one who used a mix of public or private. At Grandpass, on the other hand, 36 percent of participants said they used the municipal service, 29 percent used a local doctor's private surgery, and 19 percent a mix of both. In both communities, CommClinic had become the first option for the majority of residents, with a slightly larger proportion using fee-based services in Grandpass than Slave Island—a difference we suggest reflects the existence of a slightly more affluent population in the former compared with the latter.

Respondents to our survey gave a range of reasons for choosing CommClinic above other services, including its competitive pricing (97 percent), convenience (97 percent), and trust (92 percent). Respondents weighed the benefit of using free public services that were only open during normal working hours and hence might incur lost earnings to attend, versus CommClinic that was also free (but charged for all prescriptions) and was open the evening. In

relation to trust, respondents told us they respected the medical staff for their involvement in a charity project; they also focused on the efficacy of the prescriptions they received, which they said were reliable because CommClinic sourced them directly from the government pharmaceutical service.

Interestingly, just 20 percent of respondents told us they were aware CommClinic was an initiative of LankaComm, and as many thought a group of doctors had started it as a charity project. However, 60 percent said they did not know. Beliefs ranged widely concerning the motives of whoever was behind the project, from the idea that CommClinic was a business run for profit, a social service run for political gain, a form of *sadaqah* offered by LankaComm's Muslim owners, or as a "help for the poor people" offered by a benevolent corporation. We detected a slight correlation between those who thought CommClinic was a business and a tendency to trust the service less than those who thought it was some kind of charitable endeavor. Overall, our survey suggested that CommClinic provided the majority of residents with an option that despite a small financial outlay worked out cheaper for people in the longer term. Of the 66 residents interviewed, only two told us they did not use CommClinic at all because it was too expensive. To explore these views further, we turn now to the experiences of three residents, Rizana, Ibrahim, and Farrar.

Rizana, 43 years of age, lived in Slave Island with her husband and three children in a first floor municipal flat directly opposite CommClinic. Rizana explained the benefits of CommClinic in terms of the three key issues also important to our survey respondents—competitive pricing, convenience, and trust. Rizana's household managed on her husband's meager income as a server in a local restaurant, where he earned around Rs.400 (£2.00) per day. Like most low-income families in Colombo, Rizana's household also depended on loans to meet both short and long-term contingencies, obtained by either pawning jewelry or borrowing cash from local moneylenders. How best to deal with health care was thus a real worry. Rizana had to weigh the savings made by using the free municipal service against the time lost waiting for an appointment at the public dispensary; the high charges of a private evening clinic would make a big hole in the family's meager budget. By offering what Rizana described as a "convenient service," CommClinic provided a realistic third option that, despite a small initial outlay, worked out cheaper in the longer term.

From LankaComm's perspective, the company had launched CommClinic for people just like Rizana—the Colombo poor who normally incurred financial debts to access basic health care but who shied away from resorting to explicit charitable help. Rizana told us she was happy to pay something to access CommClinic's provision; it gave her the chance "to experience a good lifestyle," as she put it. Market inclusion allowed Rizana to access (relatively cheaply) private health care as a consumer, avoiding what she thought of as the shame and stigma of "begging" for health care. Nevertheless, Rizana was also aware that the clinic originated from the charity of LankaComm's founders. She told of her appreciation of those men, and, as a Muslim herself, hoped that Allah would bless them for their kind act in opening the clinic near her home. Rizana explained that the company's owners had created a relationship with, and an obligation to the community, through their *sadaqah*. Because of this, Rizana said, no one would complain about the service; she and her neighbors expressed gratitude for the project. As a CommClinic user, Rizana had developed a complex relationship with the clinic. She was neither an empowered consumer nor a meek recipient of charity. Rather, Rizana's statements implied that she had come to embody elements of both.

Grandpass resident Ibrahim, 52 years of age, was a retired policeman who worked in the Colombo constabulary for some 25 years. He now survived on a government pension, and was the most financially secure person we interviewed in Grandpass or Slave Island. Ibrahim lived with his wife in a three-story home that his parents had originally built, extending

their once simple two-room encroachment into a substantial house replete with middle-class lifestyle furnishings—a tiled floor, widescreen television, and washing machine. One of Ibrahim's sons worked as a driver in the Gulf, while the other was a government clerk. Both sent money home, and rather than depending upon the charity of others when things became tight, Ibrahim talked of how at Ramadan he liked to give *zakat* to "poor people in the area." For outpatient medical care, for the past ten years Ibrahim and his wife had used a doctor's private surgery located a short walk from their home. When CommClinic opened, Ibrahim decided to stay with his existing doctor. According to Ibrahim, this was partly out of loyalty, as the doctor had always provided good care in the past, but also because he viewed CommClinic as extending charity, which was something he was not in the habit of taking.

Contrasted with Rizana, Ibrahim spoke as a person secure in his ability to pay for private medical care. More than this, however, Ibrahim regarded the prospect of using even subsidized private care as something beneath him and demeaning. When asked under what circumstances he might use CommClinic, Ibrahim suggested that only if he could not afford to visit his regular doctor would he consider doing so. On the possibility of using a free municipal service, there was no question—"my sons will always take care of us," he assured us. Thus, for Ibrahim using a fully private outpatient service was an important mark of status, while using CommClinic (or worse, a free municipal service) would have damaged his status. Similarly, Ibrahim stated that he would never countenance the prospect of taking loans for medical care, even though he once did when he was younger and still struggling to raise children and pay for a household on a single wage. The avoidance of both debt and charity was for Ibrahim an important dimension of his ability to retain his self-ascribed middle class identity.

Back in Slave Island, we encountered Farrar, a Muslim woman in her late forties living in a two-room encroachment in a small lane behind the CommClinic surgery. To earn a living she sold *roti* to a local teashop for Rs.10 (£0.05) each, making around Rs.200 (£1.00) a day. Her husband, a three-wheel driver, earned another Rs.300 to Rs.500 (£1.50 to £2.50) daily. With no wealthy relatives to call on and most of the family's moveable assets pawned years ago, Farrar and her husband struggled under heavy debt. As such, when taken ill, they had little option but to use the free municipal health clinic. This did mean, however, losing time and income waiting for an appointment, extending their economic predicament further still. There was thus little in Farrar's responses to our questions about CommClinic that expressed any enthusiasm whatsoever about the benefits of subsidized private health care. While she spoke about the inadequacy of the municipal service, Farrar still had no doubt it remained a better option than CommClinic's subsidized yet still expensive private service. "Municipal health service costs nothing, why should I pay CommClinic for it?!" she asked with notable derision.

For Farrar, CommClinic either attracted fellow residents who had forgotten their right to free medical care or were far too preoccupied about their status to accept charity. Farrar's opinion was crucial in exposing something that others we interviewed did fear—that CommClinic would ultimately undermine free municipal services, leaving them only with fee-based outpatient health services. Thus, whether or not people could or should use CommClinic, despite its short-term benefits, was for Farrar tempered by a longer-term and very real worry that health care funded through general taxation would ultimately suffer, leaving the poorest like her with no options at all.

The majority of respondents to our survey framed CommClinic just as Bilal, Esmail, and Samuel might have hoped—as an affordable option that emulated the benefits of public health care and the ease of private health care. However, the meanings and values they attached to CommClinic scattered according to the diverse economic, social, and political positions of local residents. CommClinic resonated the strongest

for Rizana, who passed back and forth between liquidity and debt, finding opportunities for self-advancement through the consumption of CommClinic yet always worrying about its loss. Ibrahim, meanwhile, focused on maintaining his more secure position in the world of fully private health care. Farrar, struggling with debt, found CommClinic an unaffordable luxury. How and why people conceived of and understood those possibilities had important implications for service take-up and satisfaction, and ultimately for the longer-term outlook of the CommClinic program. It was far from clear whether CommClinic was achieving subjective transformations among beneficiaries of the kind imagined by Bilal and Esmail.

Conclusion

At the heart of our story has been a reflection on the problem of definitional consensus under conditions of market diversification and fluidity. As private health providers have gained more ground in a landscape still dominated by publicly funded providers, their "unique selling point" (USP), as it were, has been an ability to sell a narrative of convenience (short or no waiting times) that has, at least for routine health checks, trumped trust, which remains the strength of public and charitable provision. Behind this USP, and underpinning interventions like CommClinic, were shifting and often contradictory ethical stances, aspirations, and practices, from Islamic charity through CSR and social enterprise, to the needs and ambitions informing patient choices within and between private, public, and charitable provisions. What traveled with CommClinic as it passed from LankaComm's boardroom to beneficiaries in Slave Island and Grandpass were the different possible futures that our informants themselves saw in the organizational and ideational forms taken by the program. Those forms were never stable and varied according to the aspirations and realities that people held and faced as they sought to make the program a viable health care alternative.

For CommClinic's founders and managers, economic and social transformation of the poor really appeared to be achievable—if users successfully habituated the underpinning ethos of rejecting "handouts" and "paying one's way." For some local residents this did appear attractive, while for others it was insulting and politically unpalatable. Such a trade in futures articulated by the ambiguous semantics of service provisions constituted at the interstices of Islamic charity and health consumerism challenged any straightforward reading of what CommClinic might be or do for its sponsors and users alike. The idea(l) of CommClinic not only failed to travel unfettered from boardroom to beneficiary, at times it did not travel at all. The consequence was an inevitable—and productive—ambiguity over what kind of program CommClinic was "really" supposed to be.

Thus the "heterochrony" (Ssorin-Chaikov 2006) of CommClinic—the presence of multiple temporalities at work in one location—for us recalls arguments made by both Maurice Bloch (1973) and Pierre Bourdieu (1991), more recently rearticulated vis-à-vis the operations of microfinance by Chika Watanabe (2015), that gifts require specific amounts of time to be actualized as such. Reciprocated immediately, a gift takes the shape of a commodity; reciprocated never at all, and it becomes a true debt. As David Graeber (2011) argues, loans and the obligation to pay one's debts and charity and the commitment to reciprocate givers' wishes are undergirded by the same moral foundations—the responsibility to honor a return. CommClinic's operational model engendered concomitant cycles of debt and return that sought to allure, if not bind, the Colombo poor to a project of spiritual and economic renewal. At stake was not simply the delivery of health services to a population of the urban poor, but the (re)imagination of the subject of development and the relational and moral obligations between givers and recipients.

Yet as we have shown, this endeavor was not straightforward. Aside from "success stories" like Rizana's, LankaComm's wider mission was

failing—struggling to find footing in the polytemporalities of the health philanthroscape. Bilal and Esmail's hoped-for future for the poor ran up against Samuel's risk management strategy that found corporate safety in the charity model. Most of those we spoke to at the community level were happy to pay for the service but did not share a common understanding of who was responsible for the intervention, its funding model, or its social mission. Our ethnography revealed a hesitancy among the clinic's sponsors, managers, and users to endow the intervention with a final interpretation, leaving open to question its potential or efficacy as a vehicle for promoting the privatization of healthcare.

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Notes

1. The names of respondents and organizations in this article are all pseudonyms.
2. Rather the seeking to define Muslims' almsgiving with reference to Islamic canon, we focus on lived ideas and practices as we found them during fieldwork. In this article, we mention *zakat*, which is central to Islamic orthopraxis, and *sadaqah*, a routine and daily expression. *Zakat*, a form of worship, is a religious obligation performed by giving a percentage of one's wealth to specific categories of (Muslim) deserving recipients. It is distinguished from voluntary almsgiving, *sadaqah*, which is not regulated by normative rules and can be given by anyone to Muslims and non-Muslims alike (Benthall 1999; Bonner et al. 2003; Singer 2006).
3. "The Women's Bank in Sri Lanka." http://www.gdrc.org/icm/inspire/womenbank.html (accessed 1 August 2020).
4. For a recent study of precarious housing in Slave Island, see Harini Amarasuriya and Jonathan Spencer (2015).

Bibliography

Alailima, P. J. 1995. "Provision of social welfare services." *Sri Lanka Journal of Social Sciences* 18 (1&2): 1–23.

Allahyari, Rebecca Anne. 2000. *Visions of charity: Volunteer workers and moral community*. London: University of California Press.

Amarasuriya, Harini, and Jonathan Spencer. 2015. "'With that, discipline will also come to them.'" *Current Anthropology* 56 (S11): S66–75.

Appadurai, Arjun, ed. 1986. *The social life of things: Commodities in cultural perspective*. Cambridge: University of Cambridge Press.

Appadurai, Arjun. 2013. *The future as cultural fact: Essays on the global condition*. London: Verso.

Atia, Mona. 2013. *Building a house in heaven: Pious neoliberalism and Islamic charity in Egypt*. Minneapolis: University of Minnesota Press.

Benthall, Jonathan. 1999. "Financial worship: The Quranic injunction to almsgiving." *The Journal of the Royal Anthropological Institute* 5 (1): 27–42.

Bloch, Maurice. 1973. "The long term and the short term: The economic and political significance of the morality of kinship." In *The character of kinship*, ed. Jack Goody, 75–87. Cambridge: Cambridge University Press.

Bonner, Michael, Mine Ener, and Amy Singer, eds. 2003. *Poverty and charity in Middle Eastern contexts*. Albany: State University of New York Press.

Bourdieu, Pierre. 1991. *The logic of practice*. Trans. Richard Nice. London: Polity.

Caritas Sri Lanka. 2012. *Migration of Sri Lankan women: Analysis of causes & post-arrival assistance*. Report to Caritas Sri Lanka—Social & Economic Development Centre (SEDEC), Colombo.

Copeman, Jacob. 2011. "The gift and its forms of life in contemporary India." *Modern Asian Studies* 45 (05): 1051–1094.

Cross, Jamie, and Alice Street. 2009. "Misfortune at the bottom of the pyramid." *Anthropology Today* 25 (4): 4–9.

Dolan, Catherine, and Mary Johnstone-Louis. 2011. "Re-siting corporate responsibility: The making of South Africa's avon entrepreneurs." *Focaal* 2011 (60): 21–33.

Dolan, Catherine, Mary Johnstone-Louis, and Linda Scott. 2012. "Shampoo, saris and SIM cards: Seeking entrepreneurial futures at the bottom of the pyramid." *Gender & Development* 20 (1): 33–47.

Elyachar, Julia. 2005. *Markets of dispossession: NGOs, economic development, and the state in Cairo*. Durham, NC: Duke University Press.

Elyachar, Julia. 2012. "Next practices: Knowledge, infrastructure, and public goods at the bottom of the pyramid." *Public Culture* 24 (1 [66]): 109–129.

Graeber, David. 2011. *Debt: The first 5,000 years*. New York: Melville House.

Gregory, Christopher A. 1992. "The poison in Raheja's gift: A review article." *Social Analysis* 32 (Dec): 95–110.

Gupta, Monica Das, K. S. C. Dalpatadu, C. K. Shanmugarajah, and H. M. S. S. D. Herath. 2013. *Multisectoral preventative health services in Sri Lanka: Lessons for developing countries in providing public goods in health*. Policy Research Working Paper; No. 6558. Report to The World Bank, Washington, DC. https://openknowledge.worldbank.org/handle/10986/21475 (accessed 9 June 2020).

Haniffa, Farrar. 2017. "Merit economies in neoliberal times: Halal troubles in contemporary Sri Lanka." In *Religion and the morality of the market*, ed. Daromir Rudnyckyj and Filippo Osella, 116–137. Cambridge: Cambridge University Press.

Hewa, Soma. 2012. "British colonial politics and public health: The Rockefeller Foundation's effort to develop public health nursing in Sri Lanka." *Galle Medical Journal* 17 (2): 27–31.

Jones, Margaret. 2009. *The hospital system and health care: Sri Lanka, 1815–1960*. Hyderabad: Orient BlackSwan.

Kerlin, Janelle A. 2009. *Social enterprise: A global comparison*. Medford, MA: Tufts University Press.

Kumar, Ramya. 2019. "Public–private partnerships for universal health coverage? The future of 'free health' in Sri Lanka." *Globalization and Health* 15 (S1): 75.

Laet, Marianne de, and Annemarie Mol. 2000. "The Zimbabwe bush pump: Mechanics of a fluid technology." *Social Studies of Science* 30 (2): 225–263.

Lazzarato, Maurizio. 2012. *The making of the indebted man*. Los Angeles: Semiotext(e).

Muehlebach, Andrea. 2007. *The moral neoliberal: Welfare and citizenship in Italy*. Chicago: University of Chicago Press.

Ong, Aihwa, and Stephen J. Collier, eds. 2005. *Global assemblages: Technology, politics, and ethics as anthropological problems*. Oxford: Blackwell Publishing Ltd.

Osella, Filippo. 2017. "'A poor muslim cannot be a good muslim': Islam, charitable giving, and market logic in Sri Lanka." In *Religion and the morality of the market*, ed. Daromir Rudnyckyj and Filippo Osella, 217–239. Cambridge: Cambridge University Press.

Osella, Filippo, Roderick L. Stirrat, and Tom Widger. 2015. "Charity, philanthropy, and development in Colombo." In *New philanthropy and*

social justice: Debating the conceptual and policy discourse, ed. Behrooz Morvaridi, 137–156. Bristol: Policy Press.

Osella, Filippo, and Tom Widger. 2018. "'You can give even if you only have ten rupees!': Muslim charity in a Colombo housing scheme." *Modern Asian Studies* 52 (1): 297–324.

Petryna, Adriana. 2009. *When experiments travel: Clinical trials and the global search for human subjects*. Princeton, NJ: Princeton University Press.

Prahalad, Coimbatore Krishnarao. 2005. *The fortune at the bottom of the pyramid: Eradicating poverty through profits*. Upper Saddle River, NJ: Prentince Hall.

Rajak, Dinah. 2010. "'HIV/AIDS is our business': The moral economy of treatment in a transnational mining company." *Journal of the Royal Anthropological Institute* 16 (3): 551–571.

Roy, Ananya. 2010. *Poverty capital: Microfinance and the making of development*. New York: Routledge.

Rudnyckyj, Daromir. 2010. *Spiritual economies: Islam, globalization, and the afterlife of development*. Ithaca, NY: Cornell University Press.

Russell, Steven. 2005. "Treatment-seeking behaviour in urban Sri Lanka: Trusting the state, trusting private providers." *Social Science and Medicine* 61 (7): 1396–1407.

Russell, Steven, and Lucy Gilson. 2006. "Are health services protecting the livelihoods of the urban poor in Sri Lanka? Findings from two low-income areas of Colombo." *Social Science and Medicine* 63 (7): 1732–1744.

Samaratunge, Ramanie, and Chris Nyland. 2006. "Globalisation and social protection reforms in Sri Lanka." *South Asia: Journal of South Asian Studies* 29 (3): 415–434.

Silva, Kalinga Tudor. 2009. "'Tsunami third wave' and the politics of disaster management in Sri Lanka." *Norsk Geografisk Tidsskrift* 63 (1): 61–72.

Simpson, Bob. 2017. "Local virtue and global vision: The practice of eye donation in contemporary Sri Lanka." *Medicine Anthropology Theory* 4 (4): 150–170.

Singer, Amy. 2006. "Soup and sadaqa: Charity in Islamic societies." *Historical Research* 79 (205): 306–324.

Ssorin-Chaikov, Nikolai. 2006. "On heterochrony: Birthday gifts to Stalin, 1949." *Journal of the Royal Anthropological Institute* 12 (2): 355–375.

Stirrat, Roderick L., and Heiko Henkel. 1997. "The development gift: The problem of reciprocity in the NGO world." *The ANNALS of the American Academy of Political and Social Science* 554 (1): 66–80.

Tittensor, David. 2014. *The house of service: The Gülen movement and Islam's third way*. Oxford: Oxford University Press.

Trnka, Susanna, and Catherine Trundle. 2014. "Competing responsibilities: Moving beyond neoliberal responsibilisation." *Anthropological Forum* 24 (2): 136–153.

Trundle, Catherine. 2014. *Americans in Tuscany: Charity, compassion, and belonging*. Oxford: Berghahn.

Watanabe, Chika. 2015. "Commitments of debt: Temporality and the meanings of aid work in a Japanese NGO in Myanmar." *American Anthropologist* 117 (3): 468–479.